C+D

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28 November 2009

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MUR numbers soar, script volumes up again, record rise in 100-hour contracts. Welcome to...

The pharmacy pressure cooker

See page 4

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> YOU STILL DON'T GET THE FEELING PCTs HAVE REALISED COMMUNITY PHARMACY IS AN EFFECTIVE, RELIABLE PROVIDER OF PATIENT SERVICES

You're dispensing more prescriptions, earning more MUR income and being paid to provide more patient services than ever before. Well, what do you know, it would seem there is nothing to complain about and life is, well, just rosy in community pharmacy.

But we know that statistics don't always reveal the full picture and so the NHS Information Centre's annual cornucopia of pharmacy facts and figures demands a little closer scrutiny (p4).

Yes, it's great that community pharmacy in England safely and efficiently dispensed three quarters of a billion prescription items last year. And it's terrific news that pharmacists racked up an eye-watering 50 per cent hike in the number of medicines use reviews they conducted to 1.4 million. And as PSNC's Alastair Buxton rightly comments (p4), where else in the world would you find that number of standardised pharmacy interventions being delivered?

But looking back at the past 12 months, the overriding focus for the sector has been a lack of cash. The swingeing cuts in category M, rising costs of running a pharmacy business, the collapse of parallel imports and a reduction in margins have all seen contractors – from the largest multiples to the smallest pharmacies – voice concerns about the sustainability of pharmacy funding. And with the NHS Information Centre also revealing a record number of 100-hour pharmacies (p6), and many of these qualifying for establishment payments under the contractual framework, the global sum is being stretched much farther than originally agreed.

And while the latest statistics show PCTs commissioned nearly 27,000 enhanced services last year, up 4,000 on the previous year, you still don't get the feeling PCTs have realised community pharmacy is an effective, efficient and reliable provider of patient services. Commissioning 27,000 services from 10,000 pharmacies is hardly making best use of the most popular and accessible primary care health service provider.

While we're on the subject of making use of pharmacy services, the latest NHS Alliance report on commissioning (p5) is perhaps an indicator of where the problem lies. Its call for doctor-led commissioning with "organisational and personal incentives" to ensure GPs engage with the process is all too familiar. First we had fund-holding, then practice-based commissioning and now it seems we could see local clinical partnerships. But such has been the lack of impact of these schemes, you wonder why they are still being mooted.

GPs are great clinicians, but that doesn't make them great managers. If we want to truly model health services around the needs of patients, why not put together a team of health professionals selected for their clinical input who work with a business expert?

Now there's an idea.

Gary Paragpuri, Editor

Soaring dispensing volumes and MURs trigger workload warning

Contractors can't absorb increases indefinitely, industry warns

Jennifer Richardson
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Pharmacies in England each dispensed on average more than 260 extra prescription items every month in 2008-09 than they did the previous year. Those carrying out MURs also delivered on average an extra 35 each last year compared to 2007-08, official health service figures have shown.

The combined pressure on pharmacies to dispense increasing prescription volumes and deliver more services triggered fresh workload fears, sector leaders said.

Over 770 million prescription items were dispensed by pharmacies last year, according to statistics released by the NHS Information Centre this week, an increase of 6.3 per cent on 2007-08.

The rise was in line with previous years, the NPA pointed out, but added: "That isn't to say such increases can be absorbed by contractors indefinitely."

Almost 1.4 million MURs were carried out in 2008-09, 50 per cent more than the previous year. This was "encouraging" and deserving of "a pat on the back", the NPA and PSNC said.

But an NPA spokesperson warned: "With the trend being for prescription numbers to increase year on year combined with the expectation for pharmacies to offer services, the NPA is very conscious that pharmacists' time is precious."

The association was therefore working on new initiatives to cut "wasteful bureaucracy" and contain "the burden of administration that is weighing ever more heavily on our members".

The figures highlighted how "vital" the upcoming cost of service inquiry was in accounting for rising workloads, the NPA said.

The number of pharmacies in England providing MURs also jumped last year, with 83 per cent contributing to the total as compared to 73 per cent in 2007-08. However, there remained almost 1,800 pharmacies in England still not offering MURs at all. These contractors are losing £11,200 in funding available compared to those that fulfil the annual quota of 400 MURs per pharmacy.

But PSNC head of NHS services Alastair Buxton said the sector should "focus on the positive". "Yes, we would like to see more pharmacies providing MURs," he said, "but I think you would struggle to find anywhere else in the world where that number of standardised pharmacy interventions for medications are going on."

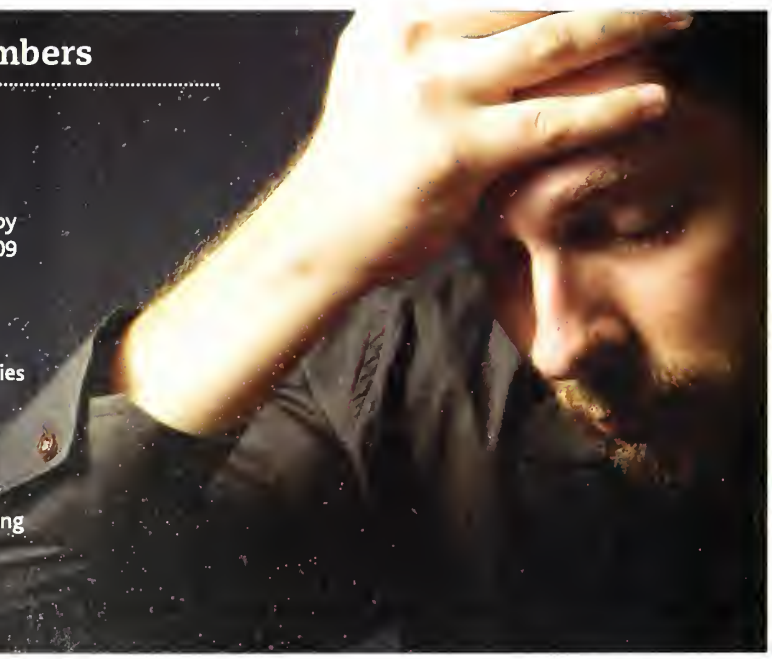
Workload by numbers

771.5m
Prescription items dispensed by pharmacies in England 2008-09

1.4m
MURs carried out by pharmacies in England 2008-09

83%
Pharmacies in England providing MURs 2008-09

Source: NHS Information Centre



Huge rise in 100-hour openings

See p6 for details

Winners and losers

[illegible]

Enhanced services continue to grow

Pharmacy services received another boost last year as the number of enhanced services being commissioned increased 15 per cent, according to NHS statistics.

Nearly 27,000 local enhanced services were commissioned by PCTs, up from 23,551 the previous year, data from the NHS Information Centre showed.

The most popular services were smoking cessation, supervised administration and minor ailments services, which are the same as the previous year.

The fastest growing service was screening, which was last year commissioned to more than twice as many pharmacies than the year before. But some smaller services, such as gluten-free food supply and care home services, did see a drop in the number of pharmacies providing them.

Alastair Buxton, head of NHS services at PSNC, called the findings "very promising" overall. He said he thought the increase in screening might be down to NHS healthchecks, but that he was hoping for some extra details next year on which screening services were being commissioned.

But Stephen Fishwick, head of external relations at the NPA, warned that the progress must not be reversed when PCTs come under financial pressure in the future.

PCTs were also asked about pharmaceutical needs assessments, which will be used to replace the current arrangements for awarding pharmacy contracts.

Last year just 34 per cent of PCTs reported that they had carried out a needs assessment, with only 12 PCTs, or 8 per cent, saying they had published that assessment.

Mr Buxton said he was not discouraged by the low figures, as he believed many PCTs were waiting for new regulations on PNAs to come into force. **ZS**

Picture Owen Humphreys/PAV/Press Association

Pharmacists in Cumbria have battled heavy flooding this week to ensure vital NHS services get through to stranded patients. John Urwin of Urwin Chemists in Seaton told C+D that patients had continued to receive their medicines and have access to doctors despite the disruption. Boots and JWW Allison & Sons Ltd Pharmacy in Cockermouth (pictured) were both closed by the deluge. Mr Urwin said access to the nearest GP surgery had been hindered by a damaged bridge, so GPs were operating a limited service from his consultation room. He said: "There have been lots of problems, but everyone is working very flexibly." ZS

Lloyds sells health centre business

Lloydspharmacy has sold its health centre business to counter the "difficult" funding situation in community pharmacy, the multiple's chief has told C+D.

But health centre pharmacies remain a Lloydspharmacy priority, managing director Richard Smith said, despite the sale of Sapphire Primary Care Developments (SPCD), which was announced this week.

The multiple sold SPCD for £6.8 million to primary care developer Ashley House and acquired a 10 per cent stake in its former rival.

The sale had been two years in the planning, Mr Smith told C+D, motivated by "a more cautious approach" to investment due to lack of funding continuity in pharmacy.

But health centre pharmacies remained "key to our strategy", he added, and the sale was a "win-win" situation for Lloydspharmacy due to the stake in Ashley House. This gives the multiple preferential access to future pharmacy opportunities within the developer's health centres.

"We get some cash on the balance sheet to reinvest in pharmacy," Mr Smith explained, "and we get better access to the health centres."

Proceeds from the sale would be invested in the infrastructure of the Lloydspharmacy chain, he said, including IT and EPOS systems.

Mr Smith's comments came after he called for a contract overhaul to prevent investment in pharmacy being cut, at the C+D Conference in Birmingham last month.

Lloydspharmacy finance director Andrew Willetts has joined the Ashley House board as non-executive director. **JR**

Reward GPs to commission, says report

Pharmacists should be part of a team of local experts to commission health services, the NHS Alliance has said – but only if led by doctors driven by incentives.

The commissioning taskforces, labelled Local Clinical Partnerships (LCPs), are the key recommendation of a report suggesting a replacement for practice-based commissioning (PBC) by the NHS Alliance and Nuffield Trust. Under the proposals LCPs would have budgets to commission local health services and would be mostly "doctor-led", with "active involvement" from pharmacists and nurses.

The rethink of primary care commissioning was necessary after the lack of consistency in services created by PBC, report co-author and NHS Alliance director of PBC Julie Wood said.

However, "organisational and personal incentives" would be needed to ensure GPs engage with the scheme, Ms Wood added.

When asked why GPs should lead rather than be part of a team, a spokeswoman for the NHS Alliance said there was "strong evidence" that commissioning worked best when doctors played a central role, but that the emphasis of the report was on involving a "diverse range of professionals". **CC**

In brief

Vaccinations extended

Children between six months and five years are to be offered the swine flu vaccine as the programme continues to roll out across the country, the chief medical officer Sir Liam Donaldson has said in a letter to all community pharmacists. To read the letter in full, go to **www.chemistanddruggist.co.uk**

Four reclassifications

Loratadine 10mg tablets, terbinafine hydrocholoride 1 per cent cutaneous solution as a single application, and combination nicotine patches releasing 15mg over 16 hours together with nicotine 2mg gum have become GSL. Alclometasone dipropionate 0.05 per cent w/w cream is now a P medicine. **www.mhra.gov.uk**

Vicks Sinex recall

Procter & Gamble has voluntarily recalled one UK lot of Vicks Sinex nasal spray. The affected batch is Vicks Sinex Aqueous Nasal Spray Solution 15ml, numbered 9224028832.

Remote GP consultations

Pharmacists will have access to a hotline of doctors willing to offer medical consultations and authorise private prescriptions over the phone, buying group PharmaPlus has revealed. The initiative will allow PharmaPlus members to refer patients rapidly and dispense medicines immediately, the company said.

Tax cap 'too high'

A government scheme to cushion businesses in England against rates rises does not go far enough, the British Retail Consortium has said. Westminster this week confirmed business rates could rise by up to 12 per cent in April. **www.chemistanddruggist.co.uk**

Inhalers used incorrectly

Nine in 10 asthma patients use their inhalers incorrectly, anecdotal evidence from a Boots service has shown. The multiple's Asthma Inhaler Check is a bespoke MUR for the condition that includes measuring patients' respiratory flow.

Dispensary talk

Have you looked at the new information governance proposals?

"No...I guess I've had a quick look, but it's next year. We've always had something similar; patients can apply to know what data is held on them. I don't see much problem with governance, everything about what we do has governance issues, so for me it's not a problem."
Bernard Mweseka, Day Lewis pharmacy, North Woolwich

"Yes, I'm aware of it, and I've been in meetings about it but I haven't read it. Personally I feel it's another burden added to our bureaucracy. Delivering this burden is becoming cumbersome, and it's stopping me doing services."
Raj Radia, Spring Pharmacy, London

Web verdict

Yes 17%

No 83%

Armchair view: Whether it's because they are too busy or not concerned about the changes, most respondents hadn't looked at the new rules regarding data.
Next week's question:
Have you ever taken sick leave because of work stress? Vote at **www.chemistanddruggist.co.uk**

Boom time for 100-hour pharmacy openings

Highest number of successful applications since loophole introduced

Max Gosney
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A record breaking number of 100-hour pharmacies were awarded contracts last year – with nearly one in 20 premises now trading under the control of entry loophole.

Over 250 applications were passed in 2008-09, official NHS statistics revealed.

This marks the highest approval rate since the 100-hour loophole was introduced, according to data from the NHS Information Centre.

The spike comes after the government refused to suspend 100-hour openings earlier this year while it carries out an overhaul of pharmacy opening rules.

The exemption, which guarantees a contract to businesses opening longer hours, has been blamed for diluting total pharma funding.

Around 450 pharmacies in England trade as 100-hour premises, the NHS statistics showed. The highest congregation was in the north west with 79 100-hour pharmacies. The south east coast had just 19 pharmacies operating under the exemption.

The 100-hour exemption was by far the most popular route for opening under control of entry loopholes in 2008-09, figures showed.

Nearly 85 per cent of contracts awarded under control of entry went to 100-hour openings compared to 12 per cent for internet pharmacies and 3 per cent for pharmacies in large out-of-town shopping centres.

Nearly one in 20 premises in England now operates under 100-hour exemption

Control of entry exemptions will continue to operate while the government agrees legislative changes granting PCTs greater say over contract applications. A task force is due to report by spring 2011.

Multiples fuel boom in pharmacy numbers

Growth by multiple chains fuelled a rise in the total number of community pharmacies in England for the fourth successive year, NHS figures showed.

Contract numbers hit 10,475 in 2008-09, with multiples boosting market share to 61 per cent.

Multiples, defined as chains of six or more pharmacies, recorded a like for like increase of 190 contracts, data revealed. Independents' numbers fell by six contracts in the same period.

Milton Keynes PCT was the most multiple dominated region, with 88 per cent of pharmacies owned by chains. Islington bucked a national trend for falling independent market share with 84 per cent of pharmacies in chains of less than six.

Overall, the number of pharmacies increased by 184. Numbers have increased year on year since 2005-06 – the same time that current contract exemptions launched. **MG**

Pre-reg exam overhaul planned for next year

The pre-registration exam will be rebranded and a cap will be placed on the maximum time allowed to qualify as a pharmacist, the new regulator has said.

The exam will be changed to the 'Registration Assessment', according to proposals by the General Pharmaceutical Council (GPhC).

Students will be limited to a total of eight years to complete the MPharm degree, pre-registration year and exam, and fourth attempts to pass the test would be abolished under the proposals.

The GPhC said the changes will replace the current RPSGB bylaws once it takes over as regulator, expected to be in April 2010. **CC**

Do you back the pre-reg shake-up?

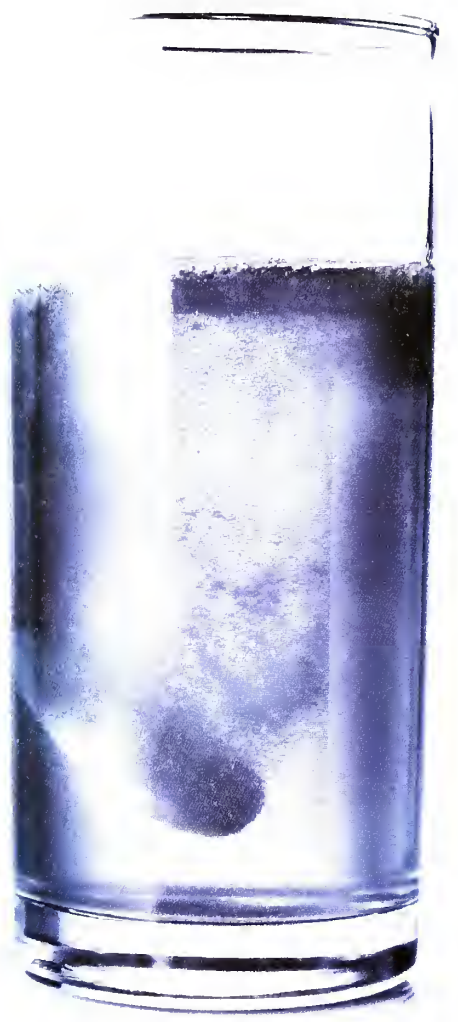
See the consultation at www.pharmacyregulation.org

PCT Investigation

Next week

How good is your PCT? Read the results of C+D's investigation, exclusively online from November 30

Go to www.chemistanddruggist.co.uk



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Flu vaccine review

The European Medicines Agency has reviewed further data on the centrally authorised pandemic vaccines Celvapan, Focetria and Pandemrix. It reaffirmed the positive balance of benefits and risks in the context of the current H1N1 influenza pandemic. Further data will become available in the coming months.

MHRA raids

The MHRA has made three arrests and seized £300,000 worth of illicit medicines as part of a crackdown on online sales of counterfeit drugs. The raids were part of an international campaign organised by Interpol and the World Health Organization.

Product recall

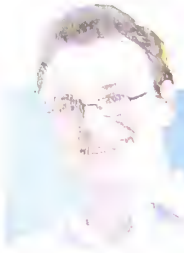
Teva is recalling Peptac Peppermint Liquid (IVAX livery) (Pip code 318-4488) and Peptac Liquid Aniseed Flavour (IVAX livery) (Pip code 214-5621) as a precautionary measure. Remaining stock should be quarantined and arrangements made for return to the wholesaler from whom it was purchased. For more information, call 0800 590502.

Antibiotic campaign

NHS Bedfordshire is encouraging people to go to pharmacists before visiting doctors for health advice this winter, as part of the PCT's annual campaign to reduce the overprescription and overuse of antibiotics.
www.bedfordshire.nhs.uk

Top of the technicians

Lloydspharmacy has named Rebecka Saunders, from its Farnham Common branch in Buckinghamshire, as its technician of the year. She beat three other finalists to collect the prize.
www.chemistanddruggist.co.uk



Pharmacist who drank morphine drug struck off

Stealing Oramorph was "abuse of trust", RPSGB hearing rules

A Shropshire pharmacy manager who regularly drank a morphine-based medicine at work to ease back pain has been struck off the register.

Hazel Wilkinson, of Tudor Gate, Shrewsbury, was caught after colleagues reported their "suspicions", the RPSGB hearing was told.

Panel chair John Burrow said: "This was planned and premeditated and an abuse of trust in a position as a pharmacist. It was dishonesty involving addictive drugs."

Mrs Wilkinson, who did not attend the central London hearing, admitted consuming Oramorph "from patient stock and patient returns", the panel was told.

When quizzed by Karen Slater, who was Rowlands area manager at the time, Mrs Wilkinson had said she "needed it for pain in her back, had seen her doctor many times, and had helped herself for 12 months".

Insisting she was "fine and didn't make mistakes" after consuming the medicine, she also claimed she was not "addicted to it but had no other choice if she wanted to work".

Mrs Wilkinson suffered back pain following a car accident more than 20 years ago, the panel heard.

Mrs Slater added: "She had a long history of mental illness – she suffered bipolar – being sometimes extremely happy and sometimes down. She was erratic."

Mrs Wilkinson was accused of dishonestly taking the medicine between September 17, 2007, and September 17, 2008, from the pharmacy, supplying the drug otherwise in accordance with the regulations while failing to be "honest and trustworthy".

Tom Rider, for the Society, told the panel Mrs Wilkinson "stole an unknown quantity of Oramorph from patient stock and patient returns and during the 12-month period there was a discrepancy of 1.2 litres".

A medicines counter assistant at the store said her suspicions were aroused when Mrs Wilkinson "froze" when her colleague arrived in the same room on one occasion and then placed a bottle of Oramorph back onto the shelf.

Mrs Wilkinson has three months to appeal. **UKL**

Doubts over cost of service inquiry

Contractors are worried by "uncertainty" surrounding the PSNC and Department of Health cost of service inquiry, Alliance Healthcare's customer forums have found.

Chris Martin, chair of the forums that canvas views from independent pharmacy owners, said: "They feel that the contract has changed now.

"A lot of over the counter business has moved to supermarkets and other things are having a negative effect on margins. People are looking forward to seeing what the inquiry will say." However, he added there were feelings of doubt over its eventual impact.

Mr Martin said: "Originally it was the start of next year, and then the spring. Now there's a feeling it could be summer. People are disappointed that it seems to keep getting further away."

Chris Martin: contractors are worried

The cost of service inquiry launched earlier this month (C+D, November 7, p5) and aims to map out accurate costs for running a pharmacy business.

The findings, due next April, will help inform negotiations for next year's contract package.

But contractors voiced concerns that recommendations will be hamstrung by a cut in government spending, Mr Martin reported.

Other matters discussed at the forum included drug supply problems, responsible pharmacist regulation and fuel surcharges. **JC**

Opioid use in cancer should remain unchanged

Cancer charity officials have warned that pain treatments should remain unchanged, despite research results suggesting opiate-based painkillers may be involved in encouraging cancer spread.

"These drugs have a long history of providing effective pain relief to many people with cancer," Cancer Research UK science information officer Dr Laura Bell told C+D.

She added that it was too early to tell whether opiate-based painkillers have an effect on cancer growth. "Much more research would be needed to justify changing the way opiates are used to treat people with cancer," she added.

A spokesman for the British Pain Association agreed. "The benefits of providing morphine to relieve the severe pain of cancer far outweighed the possible risk," he said.

The comments follow US research that found opiate-based painkillers such as morphine could encourage cancer cells to grow and spread.

The researchers showed morphine receptors found in non-small cell lung cancer could be implicated in the production of both insulin-like growth factor and endothelial growth factor, both of which are implicated in cancer proliferation. **GMA**

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HP-0250 Date of preparation October 2009

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Desderman gel is handy on the go

Schülke & Mayr is launching a pocket sized version of its Desderman International disinfectant alcohol hand gel for consumer use.

The launch is timed to meet the ever growing demand for portable and efficient hand disinfectants, says the manufacturer. A larger size of the gel is already in use in hospitals and dental surgeries in the UK.

The product is claimed to be effective against viruses such as influenza, swine flu, Hep B, Hep C, HIV, Polio, Herpes Simplex and bacteria including MRSA.

The gel contains emollients and is formulated to be fast drying and leave no sticky residue.

The launch will be supported by a consumer PR campaign in target media and on key websites beginning in January.

Point of sale material for pharmacists includes a counter top display unit and customer information leaflets.

Price and Pip code: £2.99 (50ml), 348-2221
Schülke & Mayr UK
Tel: 0114 254 3500

Fem-X supplement gets intimate with women

HealthAid is launching a supplement formulated to help women who are experiencing a decline in sexual desire.

Fem-X tablets contain a blend of essential amino acids, vitamins and minerals together with Siberian ginseng.

HealthAid claims the product "helps enhance a woman's intimacy".

"Sexual health concerns are not only experienced by men, but are becoming increasingly common amongst women as well. It is not unusual for a woman to experience a decline in sexual desire at some point in her life," says the company.

Price and Pip code: £14.99 (60 tablets), 346-2579
HealthAid
Tel: 020 8426 3400
www.healthaid.co.uk

New look Beechams All in One

GlaxoSmithKline Consumer Healthcare is phasing in new packaging across its entire Beechams All in One range.

The move is designed to bring all the products into line with newest additions Beechams Ultra All in One Capsules and Beechams Ultra All in One Hot Lemon Menthol drink.

The new packs feature metallic board to clearly differentiate Beechams All in One from the base range and reflect its premium positioning.

GSK says the new look will create strong impact on shelf, improving stand-out and blocking.

Beechams All in One is now the largest Beechams sub-brand and has driven the majority of the Beechams brand growth over the last three years (Nielsen MAT three years to October 3, 2009.)

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Macleans glides into ice dance sponsorship

GlaxoSmithKline's Macleans brand will sponsor ITV's Dancing on Ice when the live ice skating championship returns to TV screens in early 2010.

In the fifth series of the programme, superstar duo Jayne Torvill and Christopher Dean will be back to train a team of well-known faces in the art of dancing on ice.

The sponsorship package will also extend off air across ITV's online, interactive and mobile offerings.

GlaxoSmithKline believes that Dancing on Ice is a strong natural fit for the Macleans brand. "Macleans is all about giving people confidence in social situations and the sponsorship will allow us to build on this platform because performing on ice is certainly all about confidence," comments Carol-Ann Stewart, marketing director for mouthcare.

GlaxoSmithKine Consumer Healthcare
Tel: 0845 762 6637

Vitabiotics launches men's supplement

Vitabiotics is introducing a one-a-day vitamin supplement for men who wish to support their reproductive health.

Wellman Conception is targeted at men who are about to start trying for a family with their partner and wish to look after their diet and lifestyle in preparation.

The tablets combine antioxidants, vitamins and minerals with amino acids, L-carnitine, L-arginine and folic acid.

The manufacturers say the supplement can be taken for three to six months before a man starts trying for a baby, to help build up his body's nutritional stores.

The launch is supported by a national advertising campaign and PoS material.

Price and Pip code: £9.74 (30), 348-1017
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And now for the good news

> EILEEN'S ARRIVAL HAS BEEN THE BEST BIT OF NEWS WE'VE HAD FOR SOME TIME

Eileen, our new part time counter assistant, has been with us for nearly two months. She is learning fast, enjoying herself, and has become suitably battle hardened without losing any enthusiasm.

Eileen now recognises the most common OTC medicines, regular customers and the common pitfalls, and her confidence is growing by the day. Perhaps most importantly in a small pharmacy, she gets on famously with Margaret and Jean.

Of course there have been a few setbacks. Our patient from hell, Mr Hardwick, nearly reduced her to tears on one occasion with a particularly rude comment. And we all shared in her anxiety when she handed out the wrong prescription to a patient because she'd forgotten to check their address. Luckily we got the prescription back and no harm was done. Dealing with difficult customers and the importance of SOPs are two of the most important lessons for counter staff and Eileen will now remember these forever more.

Eileen's fresh pair of eyes have already provided valuable insights on a number of occasions. Many things happen in the pharmacy simply because that's the way they've always been done, rather than because they're a particularly good idea. Eileen has pointed out a number of anomalies in the shop layout, as well as price comparisons with local competition.

Sometimes it takes a fresh pair of eyes to reveal the bleedin' obvious. For example: "Why have you taken down that lovely looking old certificate and replaced it with that cheap piece of card?" I have taken my beautifully framed RPSGB certificate home as a souvenir because I needed the space to display my new responsible pharmacist (RP) sign. I have replaced an elegant, professional looking, relatively-difficult-to-forge certificate with a piece of card with my name on.

I have seen hand-written RP signs in some pharmacies, and many already look decidedly dog eared. Anyone can make their own RP sign and turn up for work, pretending to be a locum – who's to know? I dread to think how long it took eminent committees to come up with this idea only for Eileen to see it for the stupidity it really is.

Here's a good one: "Why is it such a drawn out procedure for people to get Tamiflu when they can get their prescriptions dispensed so quickly? I can't see how we'll cope if this pandemic takes off." Eileen could have designed a better system than the countless Whitehall mandarins and PCT jobsworths who've made it such a mess.

There's nothing worse than making a poor or unlucky recruitment decision and Eileen's arrival has been the best bit of news we've had for some time. With careful investment in training and welfare, I hope to reap the benefits of a happy, well trained member of staff for years to come.

Will it be a brave new world?

> PROMISE AND OPPORTUNITY MAY BE SQUANDERED IN CAUTIOUS CONSERVATISM

It's taken some time but now we have arrived; potentially a brave new world for healthcare is on the horizon as local commissioning groups (LCGs), each with a community pharmacist, hold their inaugural meetings across Northern Ireland.

The reorganisation of health, a project started under a direct rule minister, yet as a plan dismissed as inadequate by minister Michael McGimpsey when he took over, has now, finally, been completed.

The structure is simple: a slimmed down DHSSPS that provides the strategy and the money, a health and social care board that commissions healthcare, an independent public health agency to promote public health, and five LCGs that add a local dimension and buy services to address local health need. So with these structures in place, will this new way of working really improve our health?

Health and social care in NI is big business. We spend £11 million per hour of an annual budget of £4.8 billion – that is 47 per cent of the block grant from Westminster. Indeed the Belfast Health Trust alone spends an annual budget of £1bn.

We have huge social inequalities in Northern Ireland. In West Belfast a man dies at 68 years; in North Down he dies at 84 years. This is the problem and the challenge for our restructured health system.

The new structure is being told to be bold, to do things differently, better, more efficiently, yet the scope for improved performance may be a mirage. It will take some considerable courage on behalf of LCGs to take money from an existing service to fund an innovation in the hope of getting a better outcome. Politically this will be difficult. LCGs have representatives from the main political parties – will they embrace a new way of working or will they defend the status quo so they can improve their election chances?

So much of the health spend is already committed year-on-year in block payments to the trusts and to primary care. With cutbacks of 3 per cent each year for three years, where is the money to do things differently?

One key issue for me is that where the structures now in place hold such promise and opportunity, this may be squandered in cautious conservatism, our tragic national trait. I asked one of the chief executives of the board what his organisation's mission and vision is. His answer didn't exactly trip off the tongue and is something to do with efficiency and better value for money.

If the board's vision is not simplified to one simple focus – addressing the massive social inequalities in health – then we are committing ourselves to making the same mistakes healthcare managers have made for the last 60 years. Yes, we are making better, cheaper widgets, but sadly we are making the wrong widgets.

Terry Maguire is a community pharmacist in Northern Ireland

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Features

Update

Your weekly CPD revision guide

Parkinson's disease: part 2

The rationale behind drug treatment for Parkinson's disease

Russell Greene MRPharmS

This article reviews drugs for treating Parkinson's disease (PD) and looks at how they are used. The pathology, clinical features and approach to management of PD were covered in last week's Update (C+D, November 21, p17, and online at www.chemistanddruggist.co.uk/update).

Table 1 overleaf describes the approach and rationale behind enhancing dopamine transmission.

Levodopa

Action and side effects Levodopa is active only after being decarboxylated to dopamine. If this occurs before it crosses into the brain, the dopamine produced stimulates dopaminergic receptors in the heart and the gut, causing unwanted effects such as tachycardia, hypotension and severe dyspepsia. However, when given with peripherally acting decarboxylase inhibitors (DDXIs), most levodopa passes unchanged into the brain, where it is taken up by neurones in the nigro-striatal pathway, decarboxylated and released as dopamine to replace the losses caused by PD. This usually gives significant symptomatic relief, but dopamine released elsewhere in the brain can, paradoxically, cause other movement disorders as well as psychiatric effects.

Biopharmacy/kinetics Oral absorption is slow owing to the inhibitory effect dopamine has on gut motility. This contributes to the dyspepsia. Even in the presence of DDXIs, some dopamine is released in the gut and the liver before brain uptake, although this is 75 per cent less than in their absence. Dopamine breakdown via COMT and MAOB was described in the previous article (C+D, November 21, p17, and online at www.chemistanddruggist.co.uk/update).

Dosage The initial levodopa dose has to be titrated slowly according to response, both beneficial and adverse. The dose may be changed every two to three days. The aim is to achieve the right balance of levodopa and DDXI, given at the appropriate intervals. Some patients fail to tolerate levodopa at all – this is called primary failure. Others may need a mixture of formulations and unusual dosing regimens to achieve satisfactory control. Once the most suitable daily dose has been found, care must be taken to ensure stable serum levels using modified release preparations and/or frequent daily dosing. Doses should be given with food to minimise GI side effects, but simultaneous heavy protein meals should be avoided because they will reduce brain uptake of levodopa.

Long-term use Inevitably, after an average of five to 10 years, levodopa efficacy tends to wear off and the adverse effects multiply. Eventually this can lead to what is known as secondary failure. The patient may start to notice a more rapid fall off in effectiveness after each dose – the 'end of dose' or 'acute on-off' effect. This may be caused by more rapidly declining serum levels, and a temporary solution is to reduce the dose interval, giving the drug perhaps more than six times daily. Alternatively enteral infusion can be arranged, such as the Duodopa intrajejunal system, which avoids the stomach. Dopamine analogues may also be used in continuous delivery systems eg subcutaneous (apomorphine) or transdermal (rotigotine).

More serious are the true 'on-off' complications where control may fluctuate unpredictably, with the patient suddenly freezing or relaxing within minutes. The cause is unknown, but it usually accompanies disease progression and heralds secondary levodopa failure. It may involve a decline in the numbers of neurones capable of decarboxylating levodopa to dopamine.

At this stage patients are usually starting to experience more serious side effects from higher doses, including non-Parkinsonian movement disorders, and they may develop psychiatric symptoms and dementia. Treatment at this stage becomes very difficult and other drugs will need to be added.

Precautions and interactions Care is needed using levodopa in the presence of cardiovascular or psychiatric disease. Withdrawal, if necessary, should always be done slowly. Dopamine blocking drugs, notably the typical antipsychotics (eg haloperidol) and metoclopramide, will interact to block levodopa action, whereas amine enhancers like MAOIs will intensify both action and side effects. If psychiatric symptoms or side effects need treating, the newer atypical antipsychotics (eg quetiapine) can be used, while for nausea domperidone should be used because it does not cross the blood brain barrier, unlike metoclopramide.

60-second summary

What's the current thinking on initiating treatment in treating Parkinson's disease?

The threshold for starting treatment can be lower in older patients but in younger patients it is important to postpone starting levodopa for as long as possible.

What treatments are used?

In younger patients, the current trend is to start on dopamine agonists, though older patients are usually started on levodopa as their lower life expectancy means they are less likely to experience long-term levodopa failure.

What happens in the late to terminal phase?

As the primary therapy becomes less effective, it is normal to combine levodopa with a dopamine agonist.

This article (Module 1505) can help in the following CPD competencies: C1a, C1c, C1d, C1a, C3e.
See http://tinyurl.com/68ox7b

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Update extra: Do you know your accountable officer from your PPS? Is inspection, or how to deal with running balances? To test your CD knowledge, take the C+D controlled drugs quiz at www.chemistanddruggist.co.uk/cd-quiz

Test your knowledge in the CD quiz

Levodopa adjuncts

As levodopa effectiveness declines, drugs may be added that prolong the clinical effect of each dose by blocking dopamine breakdown in the CNS. These include MAOB inhibitors (eg selegiline) and COMT-inhibitors (eg tolcapone). These may produce a temporary extension in the window of control. Note that MAOB inhibitors do not have the hypertensive 'cheese reactions' that conventional MAOA antidepressants do.

Dopamine agonists

Drugs such as pramipexole, ropinirole, rotigotine and apomorphine directly stimulate dopamine receptors. They easily cross into the brain and do not require activation by decarboxylation; thus they provide a useful alternative or adjunct to levodopa, especially after secondary failure. However, their advantages have their downside: because they are immediately effective, their action cannot be protected, as can levodopa, by DDXIs. They therefore cause more peripheral side effects (gut, cardiovascular system). They are increasingly used as first line therapy so as to delay starting levodopa. Side effects are similar to levodopa, but there are fewer long-term problems. However, older ergot-derived dopamine agonists (eg bromocriptine, pergolide) can cause serious systemic fibrotic reactions and are now avoided.

Other agents

Anti-muscarinics (anticholinergics) such as procyclidine and benzhexol are descended from traditional PD remedies (belladonna derivatives). The original theory that dopamine loss in PD causes an imbalance between acetylcholine and dopamine that can be restored by an anticholinergic is now discredited; however, they are effective for symptoms of tremor uncontrolled by levodopa and remain useful in treating some of the extrapyramidal side effects of antipsychotic drugs such as chlorpromazine. Their main drawback is psychiatric side effects, which can exacerbate PD psychiatric symptoms. Amantadine, the antiviral, also has a weak anti-Parkinsonian action.

Strategy

Despite much research and after several dashed hopes, it is not yet possible to recommend prevention strategies or any drugs that will reverse or even slow disease progression; eg at one time there was hope that the antioxidant action of selegiline might slow the disease, but the evidence does not now support this. All treatment is essentially symptomatic, and it must be realised that as the disease progresses, treatment will become gradually less effective. At all times management must involve measures to maintain independence, mobility and quality of life.

Once symptoms have become evident and diagnosis made, management can be considered to pass through three phases:

In the early phase, symptoms may be mild and tolerable and drug treatment may not be required. However, other measures should be introduced as appropriate, including counselling, occupational therapy, physiotherapy, etc. In younger patients it is particularly important to delay drug therapy, but the threshold can be lower for older patients.

Table 1. Enhancing dopaminergic transmission

Approach	Rationale	Drug group and examples
Supply dopamine precursor	Increase dopamine level in base ganglia	Levodopa
Stimulate dopamine receptors	Mimic dopamine	Dopamine agonist: • Ergot derived: cabergoline, pergolide, lisuride, bromocriptine • Non-ergot derived: ropinirole, rotigotine, pramipexole • Other: apomorphine
Reduce peripheral destruction of precursor	Increase levodopa penetration into brain	Decarboxylase inhibitor eg carbidopa, benserazide COMT-inhibitor: entacapone, tolcapone
Reduce central destruction of dopamine	Increase dopamine half-life in brain	COMT-inhibitor: tolcapone MAOB inhibitor: eg selegiline, rasagiline
Inhibit neuronal dopamine re-uptake	Maximise remaining dopaminergic activity	Amantadine
Reduce cholinergic activity	Balance diminished dopminergic activity	Antimuscarinic eg trihexyphenidyl (benzhexol), procyclidine

MAOB – monoamine oxidase-B; COMT – catechol-O-methyl transferase

2. When symptoms begin to become intolerable or to interfere with the patient's ability to cope with everyday life, drug therapy should be initiated and it will become the mainstay of treatment. There is currently no consensus on the optimal sequence of drugs – not even from Nice. The decision therefore largely depends on informed patient choice and consideration of their circumstances, clinical status and response to different drugs. For older patients it is usually advisable at this stage to start on levodopa (with a DDXI), because there will be less likelihood of them encountering long term levodopa failure in view of their shorter life expectancy than younger patients. For younger patients the current trend is to start on dopamine agonists. In each case careful slow dose titration is essential.

During this stage adjunctive agents may be needed, such as antimuscarinics for uncontrolled tremor, and attention needs to be paid to dose adjustment, dose spacing, compliance, adverse effects and formulations.

3. The late to terminal phase is marked by declining benefit from the primary therapy. The first step is to combine a dopamine agonist with levodopa. If end of dose problems occur, the dosing regimen needs to be manipulated, modified release preparations tried or MAOB or COMT inhibitors introduced.

As control becomes even more difficult, the simpler oral options start to run out, and various combinations of all the above drugs may be explored. This could allow reduced levodopa dosage and fewer side effects. Later, consideration could be given to subcutaneous apomorphine infusion, possibly on a continuous basis.

There has been some success with surgical techniques but they are not yet routine. Two basic approaches are used, in each case following scanning to identify the brain areas involved, which are usually in the basal ganglia. The approach is either highly targeted destruction or permanent insertion of electrodes that can deactivate the area using current from a battery operated controller implanted subcutaneously. This is known as 'deep brain stimulation'.

Alas, despite all these formidable techniques, many patients ultimately face a grim future as motor control and cognitive ability deteriorate. Death in PD patients usually follows a fall or pneumonia.

Russell Greene MRPharmS is a pharmaceutical writer and consultant, and former senior lecturer in clinical pharmacy, King's College London.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.

NEXT WEEK
Next week's Update will look at long-acting reversible contraception

Parkinson's disease: part 2

Why should levodopa not be taken with high protein meals? What are the disadvantages of dopamine agonists? Which drug therapy is more suitable for younger patients?

This article describes the rationale behind the drug treatment of Parkinson's disease. It discusses the dose regimes and side effects of levodopa, MAOB and COMT-inhibitors, dopamine agonists and anti-muscarinics, and includes information on treatment strategies.

Read the previous Update article about causes and symptoms of Parkinson's disease (C+D, November 21. 2009, page 17) if you have not already done so.

Update your knowledge of the drugs used to treat Parkinson's disease by reading section 4.9 in the BNF.

Read the MUR tips for Parkinson's disease on the C+D website at http://tinyurl.com/yzqbzrv. Think how you could give advice on side effects or explain to a patient why their treatment seems to be less effective.

Read more about surgical treatment and future treatments of Parkinson's disease on the Parkinson's Disease Society website at http://tinyurl.com/ylsonjg and http://tinyurl.com/yj5cmy8.

Are you now familiar with the drug regimes used in Parkinson's disease and how they change as the disease progresses? Could you explain to a patient the problems of successful drug therapy in Parkinson's disease?

5 minute test

Step 1

Step 2

Step 3

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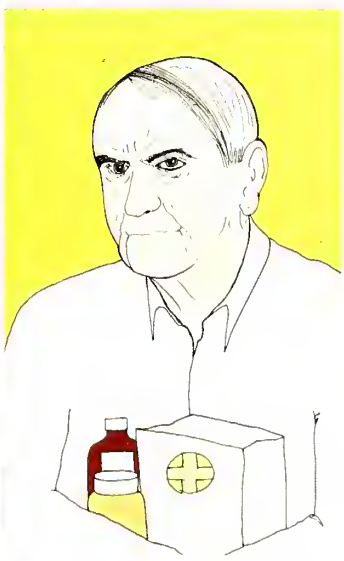
Practical Approach

Wrong medicines handed to a patient



Salma Hussein, currently working as a locum, has just started an engagement at a pharmacy that she discovers has no regular pharmacist.

The branch seems rather disorganised, and soon after it opens on her first morning she overhears a conversation between a sales assistant and the pharmacy technician, who is saying: "Oh, that's alright, I'll just do the script again and give him the right medicines, and I'll put these back into stock."

Salma decides to intervene and asks the technician to explain what is going on.

He replies: "This customer picked up his prescription yesterday, but when he got it home and opened the bag it had someone else's medicines in it. But it wasn't my fault – I think the pharmacist we had yesterday did it while I was at lunch. I handed it out later in the afternoon, but you can see the bag had this patient's name and address on the label on it."

Salma replies: "We'll have to find the right medicines or re-dispense the script, but there are a few points I'll need to talk to you about afterwards."

A search is made for the medicines but they cannot be found, so Salma decides to dispense them again. However the prescription cannot be found either.

"Not to worry," the dispenser says, looking at the labelling computer's screen. "It's all up here on the patient's PMR. We'll just re-do it from that."

"I'm afraid it's not that simple," Salma says.

Questions

1. What are the "few points" that Salma will have to discuss with the technician?
2. Why is the technician's suggestion to re-dispense the prescription from the patient's PMR "not that simple"?

Answers

1. The SOP for handing out medicines will have to be examined, particularly the sections relating to accuracy checking and transfer of medicine to the patient, to ensure the operation is efficient and safe, and the risk of system and individual error is reduced to a minimum.

The SOP should include a requirement to check that medicines inside a bag labelled with a patient's name (and address) are for that patient.

If Salma is not satisfied with the SOP, she should amend it or provide her own. If the SOP is acceptable to Salma, it is then her responsibility to ensure that it is being followed by all relevant staff.

The returned medicines cannot be re-used, because their condition cannot be guaranteed as it is not known what may have happened to them while in the patient's possession.

2. The prescription should not be dispensed from the PMR as it may be incorrect and not an accurate copy of the prescription. This possibility is more likely because whoever dispensed it originally has certainly committed at least one serious error in putting the wrong name and address on the bag label. If the original script cannot be found, a duplicate should be requested from the prescriber.

G1a, G1h, G1k, G5b, G5g, G7c.
See http://tinyurl.com/68ox7b

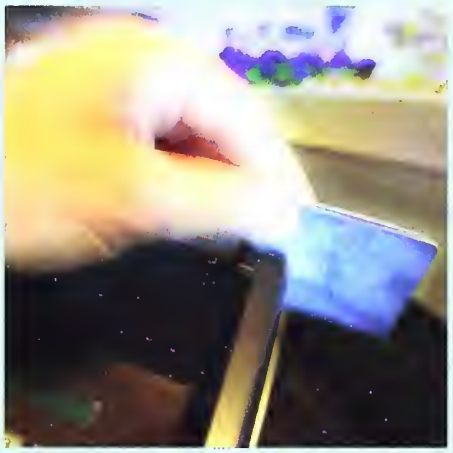
Do you have an idea for a Practical Approach scenario or would you like to write one? Email us your suggestions at haveyoursay@cmpmedica.com

To see more Practical Approach articles go to www.chemistanddruggist.co.uk/practical-approach

Have you experienced something similar? How did you resolve it? Email C+D at

This series aims to help you make the right decisions when confronted by an ethical dilemma. In the last issue of every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **ethics@cmpmedica.com**

Question of confidentiality



This is a real-life case study. A female client accuses the pharmacy of credit card theft. Unbeknown to her is the partner who is purchasing medication possibly for erectile dysfunction. The pharmacist, bound by legal and moral obligation of confidentiality to the partner, stands accused of a serious crime.

What compounds the matter is the sensitivity of the issue. What if this causes a marriage breakdown on the assumption of infidelity? What if other items were bought without her knowledge? What implication does this incident have on your professional relationships with both partners? The client herself has been loyal to the pharmacy for years, the partner only recently. What if the Viagra was being used for another indication, such as pulmonary hypertension?

The ethical dimensions of this scenario are complex but easy to identify. Confidentiality is clearly of immense importance, yet when accused of theft the pharmacist may have difficulty holding back.

The pharmacist has a number of options including:

- the invitation of a police investigation
- breaching privacy, with full disclosure
- diffusing the situation with good communication involving the husband.

With each option there are repercussions. Police investigations are long and arduous. A court subpoena would justify breach of confidentiality, but by that time much harm would have been caused to relationships all round. Although there is evidence to prove the client wrong in her accusations, not much is gained in the long run.

An unwarranted breach of confidentiality carries many risks of legal action by the partner and much resentment to say the least. And is it the pharmacist's job to alert the husband, who might deny everything?

Counter-accusation or challenging the wife to bring in the police, even in self-defence, is counterintuitive. Suggesting suspicions about her partner's behaviour could cause a complete meltdown. Ethical communication skills may be used to diffuse the situation.

Inviting the client to sit down, in private, while you look into the issue would be the first helpful step towards a resolution. This reflects empathy and respect. The next step could be gently suggesting she try other avenues of enquiry. A backlash is possible, but usually if the exchange is managed with kindness and patience, the client may be inclined to retreat.

Despite challenging circumstances, it is of the utmost important to maintain respect for patients' autonomy and privacy.

Betty Chaar BPharm, MHLaw, PhD, ethicist and lecturer in pharmacy practice, University of Sydney, Australia

The Code of Ethics and the NHS Code of Practice on Confidentiality firmly places an obligation on pharmacists to keep patient information confidential, for obvious reasons.

Disclosure of confidential information is permitted only in very limited circumstances, most obviously if the patient consents. In this case, it should be possible to raise the husband's apparent use of the credit card with the husband – it is his confidential information that appears to be in jeopardy in this scenario, not the wife's. There may be an innocent explanation that he is happy for you to share with his wife.

If the husband does not consent to you explaining the credit card bill to his wife, it is unlikely to be ethical to disclose the information to her in the absence of a statutory duty to do so (eg in response to a court order or a request from a police officer). If efforts to smooth matters over with the patient do not succeed, it may be that the only way of reaching a solution is by police involvement.

Noel Wardle is a solicitor at Charles Russell LLP, specialists in pharmacy law

G1g, G1h, G2a, G2c, G3a. See http://tinyurl.com/68ox7b

More dilemmas are online at ww.chemistanddruggist.co.uk/ethicaldilemma

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement **www.wingfieldworks.co.uk/plea/index.html**

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5. SPC Anapen 500, 300 and 150 micrograms
6. SPC Epipen 300 and 150 micrograms

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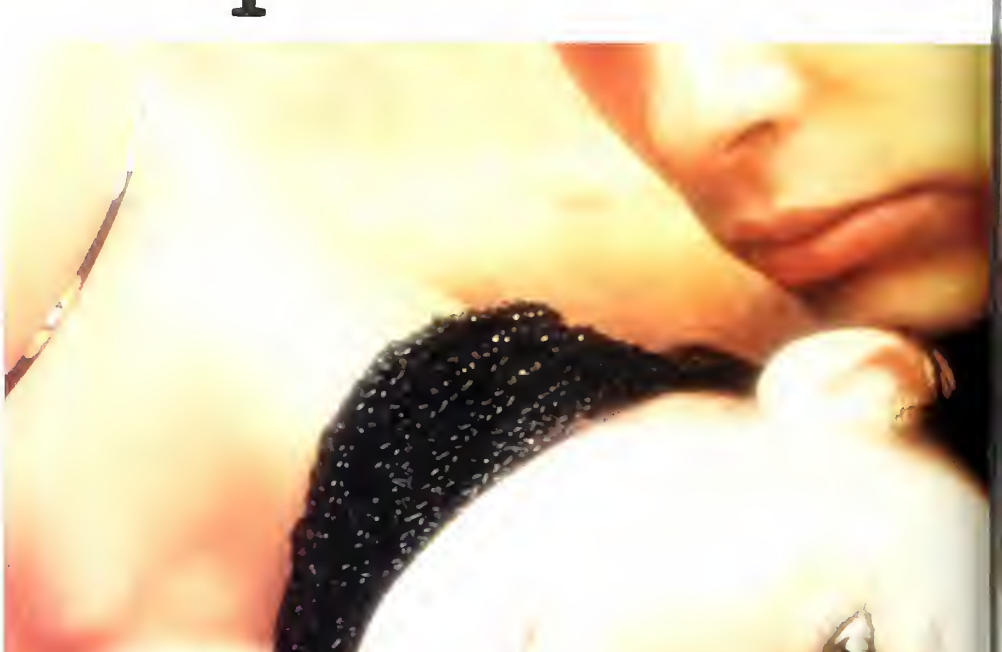
CATEGORY FOCUS

Contraception and

From chlamydia testing to EHC, consumers are turning to their local pharmacy for treatments and boosting the sector's profits, reports **Emma Wilkinson**



No longer just about selling condoms and dispensing the Pill, over the counter provision of emergency hormonal contraception (EHC) and chlamydia testing has opened the way for pharmacists to expand sexual health services across the board.

It is likely that the enhanced provision of such services will increase as PCTs and commissioners increasingly get on board with the push, as outlined in last year's pharmacy white paper, to give the profession a greater role in sexual health provision. Data from Euromonitor shows that EHC was worth £19 million in 2008, a jump of more than 10 per cent from the previous year, and sales are expected to continue to grow strongly.

In addition, chlamydia screening has in recent years been leading the drive to encourage the public to choose the pharmacy before the GP for their sexual health needs.

Offering an education

Both of these services offer the perfect chance for pharmacy to educate about sexual health in general, whether it is handing out medicines with leaflets and vouchers for condoms or signposting to other services, especially in light of a strong and widely publicised government push to lower rates of sexually transmitted infections (STIs).

Richard Hollies, OTC director at generics company Actavis UK, says 9,000 pharmacies are now signed up with the NPA's Clamelle Chlamydia Service. The £24.47 testing kit and £19.57 Clamelle azithromycin 500mg tablets – the first OTC oral antibiotic, launched in November 2008 after MHRA reclassification – "places pharmacists back at the centre of healthcare provision and public health", says Mr Hollis.

Pharmacy is in a fantastic position to boost this side of the business, with long opening hours, discreet service, private consultation rooms where needed, and a range of sexual health services in a one-stop, stigma-free shop.

Mimi Lau, director of professional and training services at Numark, says when it comes to sexual health, community pharmacy can reach those who are less likely to access healthcare any other way.

"Although condoms are available from many different outlets, only pharmacies can provide the advice and education many of these young people need," he says.

Emma Charlesworth, Numark's merchandising manager, agrees: "I firmly believe that advice and education is absolutely paramount.

"We have a niche when it comes to providing a supportive role to customers and ultimately this can lead to loyalty and increased sales. Providing sexual health counselling, support and safe sex consultation adds a USP to our service, rather than just selling Levonelle or Clamelle."

One of the most important considerations for the pharmacist is to be approachable and non-judgmental. It may seem that UK society is becoming more open about sex and sexuality, but many customers, especially the young and most vulnerable, will find it excruciatingly embarrassing to ask about STIs or EHC.

Boots pharmacist Angela Chalmers says promoting good sexual health knowledge is key and she is amazed by the number of young women who do not attend for a smear test, yet are experiencing pain or bleeding, and do not know that cervical cancer is caused by an STI.

But she adds: "Women tend to present more often for advice than men, so don't forget about the guys. Well-placed leaflets around the shaving products of local sexual health clinics can discreetly signpost men to the nearest clinic."

The rise of sexual wellbeing

Despite the rise of these enhanced services, pharmacies may do well to note that although the condom market is declining slightly, it is still worth £46m annually, according to market

Best-selling brands for contraception and sexual health

Condoms
1. Durex
2. Mates
3. Pasante
4. One Condoms
5. Femidom

Pregnancy test kits
1. Clearblue
2. Own Label
3. First Response Early Result Pregnancy Test
4. Predictor
5. Answer
6. Reveal
7. Suresign
8. Lady Care
9. Early Bird
10. Trueline

Lubricating jelly
1. Durex
2. KY
3. Replens
4. Biofem
5. Rephresh
6. Sensilube
7. Vielle

Ovulation test kits
1. Clearblue
2. Own Label
3. Persona
4. Babystart
5. Quik Check

Feminine creams
1. Vagisil
2. Balance Activ

Source: IRI value sales 52 weeks to October 3,2009

sexual health

analysts Information Resources (IRI). Durex remains the best selling brand, and has somewhat reinvented itself with its Durex Play range, which has been at the forefront of strong growth in the lubricant sub-category and introduced sex aids to the high street (see Case studies on p22).

Mike Johnson, marketing manager at Rowlands, explains that there is a move towards sexual wellbeing and sexual harmony. "It's no longer a taboo subject to talk in terms of enhanced pleasure condoms or sexual aids," he says. "Enhancing pleasure within the relationship now appears to be the universally accepted approach. As a result we have seen an influx of enhanced pleasure condoms, lubricants and sex aids.

"Durex are most definitely our best selling condom range and their range of lubricants have overtaken more traditional pharmacy lines like KY."

Mr Johnson adds that pharmacy needs to ensure its ranges are up to date with the newer more innovative products, "rather than sticking to the old variants and sizes".

Conception capital

The other side of the coin to condoms and EHC, and a huge part of the sector, relates to couples actively trying to conceive.

Valued at over £41m by IRI and growing, the pregnancy testing market is substantial. And although it saw a slight decline in sales in the past year, the ovulation testing market is worth an additional £5.5m, IRI says.

These figures are perhaps not surprising when you consider that at any one time, according to an IPSOS poll, over 30 per cent of the female population between the ages of 16 and 45 are considering trying for a baby.

Analysis by Procter & Gamble, manufacturer of ovulation and pregnancy test brand Clearblue, has shown huge demand for better information around conception, and has led to the launch of the Wish for a Baby programme, with educational literature, informative display materials and product training, including an accredited eight-module CPD course, for pharmacy.

Joanna Dee, P&G commercial manager of consumer healthcare and pharmacy, says the idea is to show women and couples who are trying to conceive that the pharmacist is a "true expert" they can speak to with total confidence.

Market insight

The past year has seen a decline in condom sales. Leading brand Durex has seen a decline across many of its sub-brands. Mates condoms bucked the trend with growth of 3 per cent, a figure partly explained by new launches. And pharmacy (including Boots and Superdrug) lost ground to the major supermarkets in its value share of the condom market.

But the small drop in condom sales is offset by strong growth in the lubricating jelly sub-category. This has been largely driven by new additions to the Durex Play range and pharmacy took the lion's share of the growth, with two-thirds of sales. Durex Play has grown category sales as well as stealing share from existing products.

Feminine creams have shown huge growth in the past year – a result of the launch of the Balance Activ brand. Pharmacy has also shown impressive capitalisation on this increase, with almost 80 per cent value growth, compared to 40 per cent value growth in major supermarkets.

Sales of pregnancy testing kits have shown a 4 per cent year on year rise, in line with the growth in birth rate. This is the only sub-category where own brand products get a look in, beating First Response into third place.

Source: IRI value sales 52 weeks to October 3, 2009. Analysis for C+D provided by Information Resources (IRI)

Case studies

Linking condoms to counselling

Numark has joined forces with manufacturer SSL to run a pilot campaign in 10 pharmacies linking a Durex promotion to emergency hormonal contraception (EHC) services.

As part of the counselling during the EHC consultation, patients are provided with a voucher for 20 per cent off Durex condoms.

Ian Facer, a pharmacist in Longton near Preston, is one of those taking part in the pilot. He has been offering a PCT-funded EHC service for four years, at £10 per consultation, and it is now rare for him to see a script for EHC.

"If they say they haven't used a barrier form of contraception, I would explain about protection and discuss sexually transmitted diseases," he says. "It is at this point I would mention the voucher."

The scheme is in its early days and so far no one has cashed in a voucher, which Mr Facer says is a little disappointing – but he remains hopeful.

"For me it's the principle, though; it allows me as an independent to differentiate myself from my competitors and I strongly believe we should work more with industry and use their expertise to add value to the patient and our service."

Brandwatch: Durex

Durex is, perhaps unsurprisingly, the best-selling brand in the condom market. But the condom market is declining (2.4 per cent over the past year). However, Durex points out that "over a significant period" of monitoring, its condoms have "consistent sales year on year".

A spokesperson for the brand says: "As the market leader, the Durex brand's behaviour mirrors the overall performance of the condom market. Market trends can be affected by many factors over a short period, including shopper behaviour and in-store promotions, for example."

In another sexual health sub-category, Durex is again the leading brand, and in this instance driving huge growth.

Just five years after launch, its Durex Play range of lubricants now has 55 per cent share of the market and is showing over 40 per cent yearly growth. The Durex spokesperson says: "This significant growth can be attributed to the brand's commitment to consistently innovating and communicating its proposition to customers."

Durex Play has also introduced a range of sex aids, including vibrating cock rings, "taking sexual enhancement products out of sex shops and onto the high street".

The spokesperson adds: "Durex Play will continue to refresh its proposition by innovating and bringing new products to the market to help grow this category even more."

Product news

£1m pledge for Vagisil

Best-selling feminine care range Vagisil last year increased its advertising spend to £1 million.

For 2010, manufacturer Combe International has now pledged a further £1m for a "heavyweight" national TV advertisement campaign.

The range, which includes a feminine wash and anaesthetic cream for relief from vaginal irritation, will be back on air in the new year.

Combe International, tel: 0208 680 2711, www.vagisil.co.uk

A hormone-free solution to vaginal dryness

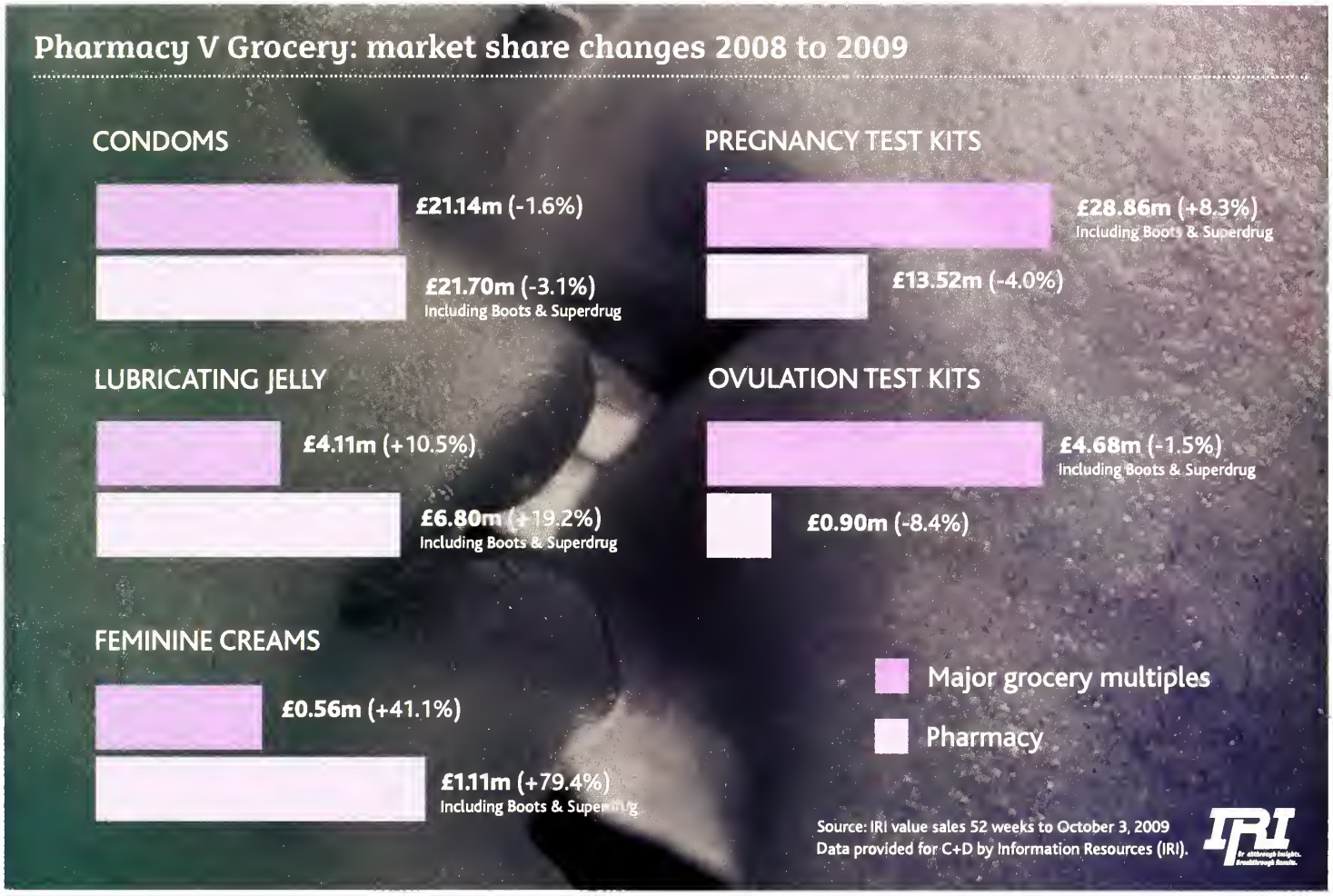
Vaginal dryness as a result of hormonal changes affects almost 40 per cent of peri-menopausal and over 55 per cent of post-menopausal women, according to a survey published earlier this year.

Moisturising gel ReplensMD offers a hormone-free solution to the problem.

It works by slowly releasing purified water from a 'polycarbophil', which clings to the vaginal wall for three days until the natural shedding of cells.

ReplensMD is available as a three-dose pack, a six-dose pack and a 35g tube (up to 12 applications).

Anglian Pharma, tel: 01256 772742
www.replensmd.co.uk



C+D AWARDS 2010

In association with NPA National Pharmacy Association

The Price is right

C+D Clinical Service of the Year 2009 winner Adrian Price tells **Gavin Atkin** about his specialist MUR

The Co-operative Pharmacy's award-winning project was a bespoke MUR service aimed at Muslims during Ramadan and the weeks running up to the festival, which involves fasting. "We thought we had a good idea," says clinical services manager Adrian Price. "When implemented it had a lot of press coverage, it went down well with the customers, and the pharmacists engaged with it; it was something a bit different and we could demonstrate the benefit."

Although going for industry awards had not been on the agenda at the beginning of the project, when the opportunity to enter the 2009 C+D Awards came round, to Mr Price and colleagues it seemed like a logical choice.

"When we won we were all delighted because it was such a team effort," Mr Price says. "It involved Muslim pharmacists who had the idea, a teacher-practitioner who helped to write the training manual and the marketing team who worked on the point of sale material to put in the window and on the counter to get customers interested."

In large organisations these things take a lot of people because there are so many disciplines that each have an interest, Mr Price adds. "Just because it's an MUR doesn't mean the pharmacist is the be-all and end-all."

It was nice to be recognised by professional colleagues and within the business, but also around the world. "In a big organisation, getting your voice heard can sometimes be a challenge," Mr Price says, "but I love talking about the project because the reception has been really positive.

"We've had people contact us from all over the world, including Australia and Denmark, and the RPSGB has launched its own campaign on the back of the work we've done. It has also been picked up on Muslim networks, including BBC Asia, and Radio One.

"One of the things I was really pleased about was that people were so willing to talk to us and that the MUR project gave us a vehicle to talk about some of the services we can offer.

"Even after all these years that community pharmacy has been banging the drum, there are still many people and even some primary care trusts that still don't seem to know, so this gave us a chance to talk about them. What you find when you do this is that people start coming back to you.

"We were very concerned about the possibility of offending anybody because of their religious beliefs – that was the last thing we intended to do. The most positive thing is that our Muslim pharmacists identified fasting as an issue; we've done something about it and demonstrated a benefit," he says.

So what are Mr Price and his Co-operative Pharmacy colleagues planning to do next? "This was the second year of the Ramadan MUR project and we ran it in 89 branches, targeting areas with Muslim populations. Next year we're going to develop it further and to work with partners – but I don't want to say too much just yet."

Does Mr Price have any advice to share with other budding award winners? "If you think you have a good idea, persevere and do it – and have the courage to keep on with it. This seemed very different to us when we first did it, even though we're a big business and very diverse."

Name
Adrian Price.

Company
The Co-operative Pharmacy.

Award won
C+D Clinical Service of the Year 2009.

Award entry
An MUR for Muslims fasting during Ramadan.

Passion?
Adrian is an enthusiastic three-nights-a-week player of lacrosse, which he enjoys because it is a minority sport that appeals to someone who likes to push the boundaries and "do something different".

Cats or dogs?
The friendship of a dog.

Favorite holiday destination?
Canada. Adrian worked there for a period and still loves the scenery and open spaces, and describes its people as very warm.

Entry for the **2010 C+D Clinical Service of the Year** category, sponsored by Martindale, is now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, online entry or to download an entry form.

How Adrian won the C+D Clinical Service of the Year Award 2009

Where did the idea come from?
Contact with customers revealed that there was an issue to address in relation to medications and conditions during Ramadan. Co-operative Pharmacy clinical services manager Adrian Price and colleagues decided to develop a training pack that would give pharmacists various points to cover during a Ramadan-related MUR, couched in terms that would be sensitive to patients' religious beliefs.

What initial support did the plan get?
Early internal support for the project came from a business plan that showed the project would offer various types of business benefits, including a financial return, engagement with customers and local communities, and public relations more generally.

What training was needed?
A training package was created by teacher-practitioners employed by The Co-operative Pharmacy. It was designed to be specific about messages to be conveyed to patients in order to avoid causing offence. Branch pharmacists were asked to work through the course and complete an assessment.

How resource-hungry was the project?
The resources required were relatively small – the aspect that required the most time and effort was the setting up and running of the training.

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Your questions answered

Q **A five-day week working pattern doesn't suit me – what can I do?**

Lloydspharmacy head of capability Barbara Sutherland (pictured below) responds:

A We all know that it is important to balance work life with your family or lifestyle commitments. Not everyone wants to work the same hours or same work pattern. And, happily, long gone are the days when the only option was a full-time five-day week. This option is still available, of course, to those who enjoy the pattern; however, there are many more options to choose from with the increasing need for flexibility in the market place.

Working as a locum obviously offers flexibility; however, you need to consider that it can be challenging in terms of a lack of certain benefits that permanent employment offers, such as holiday and sick pay, support for CPD, bonuses, consistency, social inclusion.

In permanent employment in community pharmacy, flexibility may come in many forms, such as annualised hours, part-time working, career breaks, Saturdays only etc. You should be able to discuss your flexible working opportunities with your line manager or HR department.

If your need for greater flexibility is due to child care arrangements, then you are legally entitled to formally apply for flexible working. If you wish to apply using this route, ask your line manager or your HR department for a copy of the company's policy and procedure.

Got a burning careers question? Email jrichardson@cmpmedica.com and we'll ask the experts.

My pharmacy life

Boots superintendent Paul Bennett on priorities, and pride in his work

I usually get up around 6.15am to the sound of Radio 4's Today programme, then have a cup of tea and a yoghurt for breakfast. It's a 45-minute drive to my office, but that varies if I'm on store visits or travelling to Boots' Nottingham HQ.

If it's an office day then inevitably it's meetings (which can be back to back and somewhat hectic) and, of course, dealing with emails and calls. But the days I enjoy most are when I'm in stores meeting our customers and talking to our store colleagues.

I try to get out into stores at least once or twice a week – I do miss the day-to-day interaction that I had when I was working at the coal face, but I get to experience that in a different way as superintendent. I get perhaps a broader view of what patients think of our services. I certainly don't miss standing up all the time – but that might be my age!

I had wanted to study a subject that interested me academically but would also lead to a rewarding career and where I could feel I could really make a difference, and I just thought pharmacy fitted on all those counts. So off I went to Bradford University, back in the days when new romantics were fashionable!

Although I toyed with the idea of an academic career – I was originally keen to do a PhD in pharmacology and transdermal drug delivery – it was the draw of the practical application of what I had learnt and the variety of experience that took me into community pharmacy.

There was less use of my clinical skills than I was expecting at first. But I had a good foundation in practice generally, both from my pre-reg year and years of summer vacation work with Boots, so there was no big shock.

After training with Boots I moved south with the company, becoming a second pharmacist, then

Paul Bennett describes his career path

management trainee, then store manager – a typical career pathway. I then took an area management role with Safeway and spent 15 years in various roles with that company, including eight as superintendent pharmacist and three as general manager of pharmacy, before joining Alliance Pharmacy in 2005. I took over as superintendent for Alliance in 2007 and was appointed superintendent of the merged Boots UK business in April last year.

Right now, top of my to do list is next year's activities and budgets. We're doing some exciting work at the moment on multi-channel health, to enhance and build on the online healthcare resource we have just launched, Boots WebMD. My team worked closely with colleagues across the business on that launch and I'm really proud of what they have done.

My favourite thing about my job is the feeling of satisfaction when you and your team have been a part of something that delivers something for our patients and customers that truly adds value. I don't enjoy the never-ending growth of email as a form of communication, I would much rather pick up the phone.

If I'm in the office I'll try and get away by 7.30pm, but if I'm travelling it can be a lot later than that. After finishing my law degree with the OU a couple of years ago I now have more time free in the evenings, but I tend to squander them in front of the TV or doing some web surfing. Weekends are usually taken up with walking the dog, taxiing the kids around and, if the weather's good, trying to get out in my Caterham 7.

I am motivated by being part of something that I know will make a difference and especially if I can lead it – but I'm not power crazed and I'm happy to play a team role.

I have had two big highlights in my career: my first appointment as a superintendent at Safeway and the work we did then to build the operation, and my appointment at Boots as superintendent. That's a really privileged position to hold when you consider the heritage of our business (160 years this year). I am also very proud of when my board colleagues on the RPSGB's English Pharmacy Board elected me as their first chairman in 2007, and when the same thing happened at the NPA in 2008.

I'm not thinking too far ahead just now because there is so much to focus on in the near term. I'm still sitting on the boards of the NPA, CCA and AIMp, and PSNC, which is very interesting and I get to both contribute and to listen to those who are involved in other areas of practice. So I still have my hands full, but I'm particularly interested in working with and supporting the future professional leadership body, so perhaps the future might hold something in that direction for me.

At some point, perhaps after I retire, I would also like to get more involved in the regulatory side of the profession or perhaps become a magistrate. Then again, I still quite fancy driving F1 cars for a living – it's just my age and ability that get in the way!

COMMUNITY PHARMACY **Website - New Vacancy Section**

Community Pharmacy Scotland has recently launched on its website, a new vacancy section for Community Pharmacy Scotland members.

All available vacancies can be viewed by anyone without the need for a login password but if a member wishes to post a new vacancy or edit one of their own existing vacancies then they must be logged in to the system.

There are easy to follow onscreen instructions for each field. Alternatively a document with full guidelines is available to download.

Community Pharmacy Scotland's website address is

www.communitypharmacyscotland.org.uk

If you require any further information please contact either **Graham Le Tissier** or **Jenny O'Donnell** on **0131 467 7766**

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

On the road, finally

It has been a busy week, but for once I was allowed out of the pharmacy. On Wednesday I made the long trip to Cardiff for a roadshow organised by our buying group. It was a great opportunity to meet suppliers we currently don't know and say thank you to those we already have a good relationship with.

It was a good evening, and I came away with lots of ideas that I can use to improve my business. The range of support materials produced by GSK to boost pharmacists' confidence in dealing with respiratory MURs was particularly interesting, and I am looking forward to putting these materials into practice.

As a bonus, I walked away with a year's worth of post-it notes and pens, which will definitely come in handy around the shop.

I am not quite sure what to do with the strange freebie that consisted of a pair of wheels to turn my shoes into skates, though; it's probably not the best gift for somebody as graceful as Dumbo with the balance of Bambi!

The following day I travelled to Taunton for my LPC, which needed somebody to attend the regional chlamydia conference. I was happy to do this, because it is nice to be an ambassador for pharmacy among other healthcare professionals.

Everyone was very interested to find out the secret of why Dorset has the highest proportions of chlamydia screens completed in pharmacy in the south west, and I was only too happy to tell them.

> IT'S PROBABLY NOT THE BEST GIFT FOR SOMEBODY AS GRACEFUL AS DUMBO WITH THE BALANCE OF BAMBI!

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

1859 150

A few months ago, Raiders of the Lost Archive revealed Victorian pharmacists had rolled up their sleeves and created a rival society to the RPSGB, supported by C+D. The society was still going in December 1860, when it began to establish branches across the country.

The United Society of Chemists and Druggists had, in the months since its inception, gained the support of several hundred pharmacists and was looking to kick off 1861 with a general meeting to set up a committee. The delay, C+D reassured readers, was to make sure everyone had plenty of time to find out about the society and suss out whether they wanted to join.

"This arrangement," C+D said, "will enable the members to choose their acting committee from a large list of influential gentlemen willing to serve, and prevent any fatal suspicion of cliqueism being attached to the society at its outset.

"To some minds this course of action may appear slow, but it has the advantage of being cheap and sure... a good character like this should not be periled by any outbreaks of spasmodic zeal – any flashes in the oratorical pan."

So at the end of 1860 the USCD was all set to take off, with eager pharmacists around the country jumping at the chance to be part of it. Stay tuned to find out what happened next...

Charity begins with donating computers

If you've ever wondered what you can do with your old pharmacy computers, worry no longer – it turns out you can donate your outdated machines to charity.

Lloydspharmacy has teamed up with Computers4Africa to ship out 500 of its old machines to southern Africa to help teach in impoverished schools. The computers will be inspected, tested and scrubbed clean of data before being sent out with their monitors and keyboards.

One possible destination for the cast-off hardware is a teacher training college in Tanzania. Students train with the computers before heading out with the machines – and a generator if electricity isn't available – to help teach kids in impoverished communities.

Postscript thinks this sounds like the perfect excuse for a computer upgrade, and possibly the chance to hoodwink the boss into getting a machine that can run the latest shooty blast'em-up games. Not that many pharmacists would have time to play them...

If you've got any old computers that you'd like to donate to the charity, the details are online at www.computers4africa.org.uk

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- **B:** They are the same
- **C:** Twice as fast
- **D: 3 times faster**

*Speed of release in the mouth does not imply speed of craving relief

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gsk GlaxoSmithKline
Consumer Healthcare

NiQuitin Minis Mint 1.5mg/4mg Lozenges (nicotine). Indication: smoking cessation. **Dosage:** *Adults (18 and over):* Max 15/day. One lozenge whenever urge to smoke to aid complete cessation (taper use after 6 weeks) or gradual cessation (seek advice if no reduction after 6 weeks or no abrupt cessation after 6 months). Use 1.5mg strength if smoke ≤20/day. *Adolescents (12-17 years):* Abrupt cessation only. Dosing as for adults but seek professional advice if ≥12 weeks treatment required/unable to quit abruptly. **Contraindications:** Hypersensitivity, non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those contraindicated for MI, severe dysrhythmia or CVA who are haemodynamically stable. Once discharged, can use NiQuitin as normal. Susceptibility to peptic ulcer, urticaria. Renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma. Swallowed nicotine may exacerbate oesophagitis, gastric/peptic ulcer. Pregnancy/lactation: For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. **Side effects:** At recommended doses, NiQuitin Mini Lozenges have not been found to cause any serious adverse effects. Nausea, hiccup, flatulence, GI discomfort, vomiting, diarrhoea, dyspepsia, fatigue, malaise, chest pain, oral irritation, dizziness, headache, sleep disorders including abnormal dreams, anxiety, irritability, nervousness, depression, palpitations, increased heart rate, cough, sore throat, rash. See SPC for full details. GSL PL 00079/0610, 0611. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes and RSP:** 20's £4.99, 60's £13.99. **Date of preparation:** June 2009. **NiQuitin®, NiQuitin® Minis** and the **Minis Device** are trademarks of the GlaxoSmithKline group of companies.

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References: 1. Durcan MJ *et al.* Efficacy of the nicotine lozenge in cue-provoked cravings. 66th Annual Meeting of College on Problems of Drug Dependence; San Juan, P.R., 2004. 2. GSK data on file.